DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTEO: 03/21/2014 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IX1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING 01 - MAIN BUILDING 01 COMPLETED 44E232 B. WING NAME OF PROVIDER OR SUPPLIER 03/20/2014 STREET ADORESS, CITY, STATE, ZIP CODE BLEDSOE COUNTY NURSING HOME 107 WHEELERTOWN AVENUE PIKEVILLE, TN 37367 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETION DATE PREFIX TAG DEFICIENCY) K 000 | INITIAL COMMENTS K 000 POC ACCEPTED Stories: 1 Construction Type: III (200) Constructed: approx. 1978 Fully Sprinkled Y Certified beds: 50 Census: 40 NFPA 101 LIFE SAFETY CODE STANDARD K 018 4/10/14 K 018 K 018 SS=D Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or A) WHAT CORRECTIVE hazardous areas are substantial doors, such as ACTION WILL BE those constructed of 1% inch solid-bonded core ACCOMPLISHED FOR wood, or capable of resisting fire for at least 20 THOSE RESIDENTS minutes. Doors in sprinklered buildings are only FOUND TO BE AFFECTED required to resist the passage of smoke. There is BY THE DEFICENT no impediment to the closing of the doors. Doors PRACTICE? are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 1. Waste can was removed are permitted. 19.3.6.3 immediately at the door of Roller latches are prohibited by CMS regulations room 124 by the Maintenance in all health care facilities. Supervisor/Safety Officer on March 20, 2014. 2. A new latch for the linen supply door was installed by the Maintenance Supervisor/ Safety Director on March 21, 2014.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Bunt

This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to protect corridor openings.

TITLE

(XB) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes; the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

Findings include:

stephani

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 03/21/2014 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION <u>OMB NO, 0938-0391</u> (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 44E232 B. WING NAME OF PROVIDER OR SUPPLIER 03/20/2014 -STREET ADDRESS, CITY, STATE, ZIP CODE BLEDSOE COUNTY NURSING HOME 107 WHEELERTOWN AVENUE PIKEVILLE, TN 37367 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETION TAG PREFIX DATE DEFICIENCY K 000 **INITIAL COMMENTS** K 000 Stories: 1 Construction Type: III (200) Constructed: approx. 1978 Fully Sprinkled Y Certified beds: 50 Census: 40 NFPA 101 LIFE SAFETY CODE STANDARD K 018 K 018: B). HOW WILL YOU IDENTIFY SS=D Doors protecting corridor openings in other than OTHER RESIDENTS HAVING required enclosures of vertical openings, exits, or THE POTENTIAL TO BE hazardous areas are substantial doors, such as AFFECTED BY THE SAME those constructed of 1% Inch solid-bonded core DEFICIENT PRACTICE? wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only 1. Door at Room 124 - Failure to required to resist the passage of smoke. There is properly maintain corridor doors no impediment to the closing of the doors. Doors openings potentially increases the are provided with a means suitable for keeping risk to all residents. A Staff inthe door closed. Dutch doors meeting 19.3.6.3.6 service was conducted by the are permitted. 19.3.6.3 Maintenance Supervisor/Safety Roller latches are prohibited by CMS regulations Director on March 21, 2014, in all health care facilities. regarding the importance of proper closing of all doors. 2. Door at Linen Supply Room -Failure to properly maintain corridor doors/openings potentially increases the risk to all

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

This STANDARD is not met as evidenced by:

Based on observation and staff interview, the

facility failed to protect corridor openings.

TITLE

doors closed.

residents. Maintenance

Supervisor will routinely monitor

that all doors are provided with a

Continued -

all doors in the facility to ensure

means suitable for keeping the

DX6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the Institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for missing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 program participation.

Findings include:

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 03/21/2014 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 COMPLETED 44E232 B. WING NAME OF PROVIDER OR SUPPLIER 03/20/2014 STREET ADDRESS, CITY, STATE, ZIP CODE BLEDSOE COUNTY NURSING HOME 107 WHEELERTOWN AVENUE PIKEVILLE, TN 37367 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETION DATE PREFIX TAG TAG DEFICIENCY) K 000 **INITIAL COMMENTS** K 000 Stories: 1 Construction Type: III (200) Constructed: approx. 1978 Fully Sprinkled Y Certifled beds: 50 Census: 40 NFPA 101 LIFE SAFETY CODE STANDARD K 018 K 018 C). WHAT MEASURES WILL \$S=D Doors protecting corridor openings in other than BE PUT INTO PLACE OR required enclosures of vertical openings, exits, or WHAT CHANGES WILL YOU hazardous areas are substantial doors, such as MAKE TO ENSURE THAT THE those constructed of 1¾ inch solid-bonded core DEFICIENT PRACTICE DOES wood, or capable of resisting fire for at least 20 NOT RECUR? minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is Maintenance Supervisor/Safety no impediment to the closing of the doors. Doors Director will routinely monitor are provided with a means sultable for keeping and continue to in-service all Staff the door closed. Dutch doors meeting 19.3.6.3.6 to ensure that all doors in the are permitted. 19.3.6.3 facility are properly closed and Roller latches are prohibited by CMS regulations free from obstructions. in all health care facilities. D.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR?

This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to protect corridor openings.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Findings include:

properly.

Maintenance Supervisor/Safety
Director will routinely monitor all
doors in the facility to ensure that

prevent proper closing of all doors

there are no obstructions to

and that all latches work

TITLE

(X8) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/21/2014 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING		(X8) DATE SURVEY COMPLETED		
		44E232					
NAME OF PROVIDER OR SUPPLIER BLEDSOE COUNTY NURSING HOME				/20/2014			
(X4) ID PREFIX TAG	Continued From page 1 On 3/20/2014: 1.The door at room 124 was obstructed from closing by a waste can. 2.The door at the Linen Supply room did not latch. The Maintenance Supervisor acknowledged the findings when the deficiencies were identified. Ref: 2000 NFPA 101 Section 19.3.6.3.2, 19.3.6.3.3 Failure to protect corridor doors/openings increases the risk of death or injury due to smoke/fire. NFPA 101 LIFE SAFETY CODE STANDARD		ID PREFIX TAG	PREVILLE, TN 37367 PROVIDERS PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER CROSS-REFERENCED TO THE CROSS-REFERENCED TO THE APPROVIDER CROSS-REFERENCED TO	DDE	COMPLETION DATE	
			K 022	B). HOW WILL YOU IDEN OTHER RESIDENTS HAVI THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE? All residents will be potential affected of failure to identify exits, increasing injury due to fire/smoke or other emergence Lighted directional signs were ordered and received for thes exits by the Maintenance Supervisor/Safety Director. Project will be completed by April 30, 2014.	ly the ies, e		
				Contin	ucd		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/21/2014 FORM APPROVED

		& MEDICAID SERVICES	·		OMB NO	0.0938-039	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING		(X3) DA	(X3) DATE SURVEY COMPLETED	
	44E232				00	3/20/2014	
	PROVIDER OR SUPPLIER	HOME		STREET ADDRESS, CITY, STATE, 107 WHEELEHTOWN AVENUE PIKEVILLE, TN 37367	ZIP CODE	1/20/2014	
(X4) ID PREFIX TAG	I (EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
K 022	the chapel and the identified with direc which is a gate nea exit sign at the gate. The Maintenance S finding when the de Ref: 2000 NFPA 10 7.10.1.4	exit access from the door near door near room 126 was not tional sign leading to the exit of the laundry. There is not an included a section of the laundry of the ficiency was identified. 1 Section 19.2.10.1, 7.10.1.1, the exit access and exits of death or injury due to	K	D.) HOW THE COR ACTION(S) WILL E MONITORED TO E THE DEFICIENT P WILL NOT RECUR Maintenance Supervi Director will routine the facility to ensure access is identified wi directional signage.	BE INSURE RACTICE ? isor/Safety ly monitor that all exit		
K 0561 SS=D	If there is an autom installed in accordator the Installation of provide complete or building. The system accordance with NF Inspection, Testing, Water-Based Fire F supervised. There supply for the systems are equiped.	RETY CODE STANDARD atic sprinkler system, it is not with NFPA 13, Standard of Sprinkler Systems, to overage for all portions of the m is properly maintained in FPA 25, Standard for the and Maintenance of Protection Systems. It is fully is a reliable, adequate water m. Required sprinkler ed with water flow and tamper electrically connected to the	Ko	A).WHAT CORI ACTION WILL ACCOMPLISHI THOSE RESIDE FOUND TO BE BY THE DEFIC PRACTICE? Maintenance Superv contacted Simplex G Company. Inspector facility on April 1, 26	BE ED FOR ENTS AFFECTED ENT isor crinell rs came to	4/30/	
	This STANDARD is Based on observat	s not met as evidenced by: ion and staff interview, the		measure for new star sprinklers for Reside 120, 121, 122, and 12 be completed by Api	ndard ent Rooms 6. Project to ril 30, 2014	inued	

PRINTED: 03/21/2014 FORM APPROVED OMB NO. 0938-0391

OMB NO. 0938-0391) MULTIPLE CONSTRUCTION (X3) DATE SURVEY BUILDING 01 - MAIN BUILDING 01 COMPLETED MING 03/20/2014 STREET ADDRESS, CITY, STATE, ZIP CODE 107 WHEELERTOWN AVENUE PIKEVILLE, TN 37367 ID PROVIDER'S PLAN OF CORRECTION (XB) COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DAT DEFICIENCY K 056 D.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR? Maintenance Supervisor/Safety Director will ensure that all sprinklers, when necessary to be replaced, have the same thermal sensitivity in each room. K 066

Facility ID: TN0401

If continuation sheet Page 4 of 7

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

44E232

NAME OF PROVIDER OR SUPPLIER

BLEDSOE COUNTY NURSING HOME

(X4) ID SUMMARY STATEMENT OF DEFICIENCIES
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

K 056

Continued From page 3 facility failed to properly install the sprinkler system.

Findings include:
On 1/28/2014, there were compartments (rooms) with a mix of standard (SR) and quick (QR) response sprinklers. Resident rooms 120, 121, 122, 126 had 2 SR sprinklers and 1 QR sprinkler. There is not a draft stop separating the SR sprinklers from the QR sprinklers.

Compartments (rooms) are required to have sprinklers of the same thermal sensitivity.

The Maintenance Director acknowledged the findings when the deficiencies were identified

Ref: 2000 NFPA 101 Section 19.1.6.2, 19.3.5.1, 9.7.1.1 1999 NFPA 13 Section 5-3.1.5.2, 7.2.3,2.4

Failure to properly install sprinklers of the same thermal sensitivity increases the risk of death or injury due to fire.

The deficiency affected 4 resident rooms and 1 of 4 smoke compartments in the facility. NFPA 101 LIFE SAFETY CODE STANDARD

K 066 NFPA 101 LIFE SAFETY CODE STANDARD
SS=D
Smoking regulations are adopted and include no less than the following provisions:

(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING

FORM CMS-2567(02-99) Previous Versions Obsolete

Event 10:1N2Z21

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 03/21/2014 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY A. BUILDING 01 - MAIN BUILDING 01 COMPLETED 44E232 03/20/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE BLEDSOE COUNTY NURSING HOME 107 WHEELERTOWN AVENUE PIKEVILLE, TN 37367 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (X5) COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 066 Continued From page 4 K 066 4/30/19 K 066 or with the international symbol for no smoking. A). WHAT CORRECTIVE (2) Smoking by patients classified as not ACTION WILL BE responsible is prohibited, except when under direct supervision. ACCOMPLISHED FOR THOSE RESIDENTS (3) Ashtrays of noncombustible material and safe FOUND TO BE AFFECTED design are provided in all areas where smoking is BY THE DEFICENT permitted. PRACTICE? (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are Maintenance Supervisor/Safety readily available to all areas where smoking is Director placed an all metal selfpermitted. 19.7.4 closing container at the smoking : area on March 28, 2014. B). HOW WILL YOU This STANDARD is not met as evidenced by: **IDENTIFY OTHER** Based on observation and staff interview, the RESIDENTS HAVING THE facility failed to provide a self-closing metal POTENTIAL TO BE container disposal of ashtray contents/cigarette butts at the smoking area. AFFECTED BY THE SAME **DEFICIENT PRACTICE?** Findings include: All residents have the potential On 3/20/2014, the trash can at the smoking area to be affected. had paper/foam trash and cigarette butts in it. Metal container with self-closing The Maintenance Supervisor acknowledged the cover into which ashtrays/

injury due to smoke/fire.

finding when the deficiency was identified.

Failure to provide the required receptacles at

smoking areas increases the risk of death or

Ref: 2000 NFPA 101 Section 19.7.4

cigarette butts can be emptied, was placed at smoking site by

Maintenance Director on March 28, 2014. This will reduce the risk

of injury due to smoke/fire.

Continued

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 03/21/2014
FORM APPROVED
OMR NO 1000 1004

CENTE	HS FOR MEDICARIE	& MEDICAID SERVICES			0		APPROVE
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED		
NAME OF		44E232	B. WING				(00)004 -
	PROVIDER OR SUPPLIER DE COUNTY NURSING			10	REET ADDRESS, CITY, STATE, ZIP CODE DY WHEELERTOWN AVENUE KEVILLE, TN 37367	<u>1 133</u>	<u>/20/2014 · </u>
(X4) ID PREFIX TAG	しょうしき ひとしばほれば	ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	\neg	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	OC	(X5) COMPLETIO DATE
K 067 K 067 SS=D	Continued From page 5 NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2		К 0 К 0		K 067 A).WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THO RESIDENTS FOUND TO BE AFFECTED BY THE DEFICENT PRACTICE?	SE	4/30/14
	the facility failed to frindings include: On 3/18/2014, the fr	s not met as evidenced by: It review and staff interview, lest HVAC equipment. Builty could not provide a required 4 year testing of			Maintenance Supervisor/Safety Director has scheduled an inspection of the HVAC equipment with Morgan Electric Company. All dampers will be checked to verify that they fully close. Inspection to be complete by April 30, 2014.	ie	
	applicable) shall be be operated to verify latch, if provided, ship parts shall be lubricadampers are required. The Maintenance Strinding when the definition of the parts of the definition of the parts of the part	years, fusible links (where removed; all dampers shall y that they fully close; the all be checked; and moving ated as necessary. Installed ad to be maintained. Upervisor acknowledged the iciency was identified and s are installed in the ducts.			B). HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAM DEFICIENT PRACTICE? All residents have the potential be affected.	E	
	Ref: 2000 NFPA 101 4.6.7 1999 NFPA 90, Failure to test the H ¹ increases the risk of smoke,	Section 19.5.2.1, 9.2.1, A Section 3-4.7 VAC system as required death or injury due to			be affected. Maintenance Supervisor will schedule Morgan Electric to conduct a testing of the HVAC system every four years to ensuthe dampers are properly maintained.	tre	